STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15G190	A. BUILDING 00 B. WING	05/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ARC OF NORTHWEST INDIANA INC, THE	120 AVENUE C GRIFFITH, IN 46319

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W0000		W0000		

This visit was a predetermined full recertification and state licensure survey

This survey was done in conjunction with the post certification revisit to the investigation of complaint #IN00104522.

Dates of Survey: May 9, 10 and 11, 2012.

Facility number: 000722
Provider number: 15G190
AIM number: 200234570

Surveyors: Christine Colon, Medical Surveyor III/QMRP

The following deficiencies also reflect state findings in accordance with 460 IAC 9.

Quality Review was completed on 5/22/12 by Tim Shebel, Medical Surveyor III.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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W0114	483.410(c)(4) CLIENT RECORDS Any individual who makes an entry in a client's record must make it legibly, date it, and sign it. Based on record review and interview the facility 1. failed to have a signed and dated Behavior Support Plan (BSP) and Individual Support Plan (ISP) for 1 of 2 sampled clients (client #1) and 2. failed to ensure entries made in records were legible for 2 of 2 sampled clients (clients #1 and #2). Findings include: A review of client #1's record was conducted at the group home on 5/11/12 at 10:00 A.M.. Review of client #1's BSP dated 8/11-8/12 failed to have a client, guardian or Service Coordinator (SC) signature. Review of client #1's ISP dated 8/15/11 failed to have a client, guardian or SC signature. An interview with the SC was conducted on 5/11/12 at 11:15 A.M.. The SC indicated the BSP and ISP should have been signed. No further documentation was available for review to indicate client #1's BSP and ISP had a client, guardian and SC signature.	W0114	Service Coordinator will make sure all documents are clearly and properly signed. To ensure future compliance, Service Coordinator will audit files annually and thereafter.	06/10/2012

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	2. Client #1's medical records were reviewed on 5/11/12 at 10:00 A.M., including entries by client #1's Primary Care Physician (PCP). Entries made by client #1's PCP were not legible. Client #2's medical records were reviewed on 5/11/12 at 10:50 A.M., including entries by client #2's PCP. Entries made by client #2's PCP were not legible. An interview with the Licensed Practical Nurse (LPN) was conducted on 5/11/12 at 11:50 A.M.. The LPN indicated the entries made by clients #1 and #2's PCP were not legible and were hard to read. 9-3-1(a)			

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W0183	483.430(c)(2) FACILITY STAFFING There must be responsible direct care staff on duty and awake on a 24-hour basis, when clients are present, to take prompt, appropriate action in case of injury, illness, fire or other emergency, in each defined residential living unit housing: (i) Clients for whom a physician has ordered a medical care plan; (ii) Clients who are aggressive, assaultive or security risks; (iii) More than 16 clients; or (iv) Fewer than 16 clients within a multi-unit building. Based on interview and record review, the facility failed for 1 of 2 sampled clients (client #1) and 1 additional client (client #3), to assure awake staff were present and on duty for all overnight shifts for the time period from 4/1/12- to 5/11/12. This potentially affects all clients who lived at the group home, (clients #1, #2, #3 and #4). Findings include: A review of client #1's record was conducted on 5/11/12 at 10:00 A.M.. Review of client #1's most current Individual Support Plan (ISP) dated 8/15/11 indicated "receives behavioral programming including psychotropic medications arising from Impulse Control	W0183	Adequate staffing was provided. 6/8/12Client #1 has not had any type of physical or verbal aggression in a year and Client #3 has only had 3 aggressive gestures towards staff and no physical aggression and only one incident of head banging in a year. None of these incidents have occurred during the overnight period. Therefore adequate staffing was provided. To ensure future compliance and proper staffing, Service Coordinator will audit tracking sheets monthly and logs daily for any behavioral changes that may occur.CorrectionW183 Overnight staffing is being implemented at AVE C, and will begin on 6/18/12.	06/10/2012

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	Disorder Symptoms." Review of client #1's "Positive Behavioral Support Plan" dated 8/11-8/12 indicated: "Targeted behavior - Physical Aggression...Medication Considerations: Abilify 10 mg in the morning for the clinical impression of Impulse Control Disorder." A review of client #3's record was conducted on 5/11/12 at 11:00 A.M.. Review of client #3's most current Individual Support Plan (ISP) dated 8/8/11 indicated "On a behavior plan for decreasing inappropriate behaviors." Review of client #3's Behavioral Support Plan (BSP) dated 8/11-8/12 indicated: "Targeted behavior - Banging head." A review of the actual hours worked, group home staff schedule was conducted at the facility's administrative office on 5/11/12 at 10:00 A.M.. Review of the group home staff schedules indicated no awake staff were present and on duty on 4/1/12 through 5/11/12. An interview with the Area Manager (AM) was conducted at the facility's administrative office on 5/11/12 at 11:30 A.M.. The AM indicated the group home did not have overnight awake staff scheduled. The AM further indicated there was overnight asleep staff at this			

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	group home. No further documentation was available for review to indicate there was awake staff available and on duty for all overnight shifts. 9-3-3(a)			

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W0189	483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently. Based on record review and interview the facility failed for 4 of 4 clients residing at the group (clients #1, #2, #3 and #4) to provide staff with initial and ongoing training on each clients' Individual Support Plans (ISP), Risk Plans and Behavior Support Plans (BSP). Findings include: A review of the group home staff and client list was conducted on 5/9/12 at 2:15 P.M.. Review of the list indicated Direct Support Professionals (DSP) #1 and #2 were the only two staff who worked at the group home with clients #1, #2, #3 and #4. A request for the staff who worked at the group home with clients #1, #2, #3 and #4 was made on 5/11/12 at 9:45 A.M.. DSP #1 and #2's employee records were the only records submitted for review. A review of the actual hours worked, group home staff clock in and out record was conducted at the facility's administrative office on 5/11/12 at 10:00	W0189	Service Coordinator will train all DSPs working at the group home on ISP, BSP and Risk Plans. To ensure future compliance, all DSPs will be train on ISP, BSP and Risk Plans before working at the group home. 6/8/12 Service Coordinator will re-train staff currently working at the group home on each individual client. New staff will be trained in foundations the week prior to working this includes abuse and neglect, med administration high risk plans and behavioral supports; Service Coordinator and Community Services Nurse will train new staff on each individual client before working at the group home. To ensure future compliance Service Coordinator and Community Services Nurse will train all new staff at the end of foundations and all staff annually and/or as needed.	06/10/2012

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	A.M.. Review of the group home staff schedules indicated DSP #1, #2 and 6 additional staff worked with clients #1, #2, #3 and #4 from 4/1/12 through 5/11/12. A request for staff training records was done on 5/11/12 at 10:15 A.M.. The Service Coordinator (SC) submitted documentation which indicated only DSP #1 and #2 were trained on each clients' ISP, Risk Plans and BSP. When asked if there was documentation available for review to indicate DSP #3, #4, #5, #6, #7 and #8 were trained on clients #1, #2, #3 and #4's program needs and training programs, she stated "No." No documentation was available for review to indicate all staff who worked at the group home with clients #1, #2, #3 and #4 were trained on each clients program needs. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M.. Review of client #1's most current Individual Support Plan (ISP) dated 8/15/11 indicated "receives behavioral programming including psychotropic medications arising from Impulse Control Disorder Symptoms." Review of client #1's "Positive Behavioral Support Plan" dated 8/11-8/12 indicated: "Targeted behavior - Physical			

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	Aggression...Medication Considerations: Abilify 10 mg in the morning for the clinical impression of Impulse Control Disorder." Further review of client #1's record indicated she had a personalized "Dining Plan", "Hearing Loss Risk Plan" and a "History of Seizure Plan." A review of client #2's record was conducted on 5/11/12 at 10:50 A.M.. Review of client #2's record indicated an ISP dated 2/14/11 which indicated: "Breast Cancer, history of Tuberculosis, Anxiety Disorder, Tourettes and is non verbal. Further review of the record indicated she had a personalized "Haldol Plan" and a "Yasmin Plan." A review of client #3's record was conducted on 5/11/12 at 11:00 A.M.. Review of client #3's most current Individual Support Plan (ISP) dated 8/8/11 indicated "On a behavior plan for decreasing inappropriate behaviors." Review of client #3's Behavioral Support Plan (BSP) dated 8/11-8/12 indicated: "Targeted behavior - Banging head." Further review of client #3's record indicated she had a personalized "High Blood Pressure Plan" and a "Over Active Bladder Plan." A review of client #4's record was conducted on 5/11/12 at 11:20 A.M..			

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	Review of client #4's most current Individual Support Plan (ISP) dated 11/11/11 indicated "Hypertension, Depression, Anxiety, Hearing loss and Diabetes Mellitus. Further review of the record indicated she had a personalized "Diabetic Plan" and a "Hearing Loss Risk Plan." An interview with the Area Manager (AM) and Service Coordinator (SC) was conducted at the facility's administrative office on 5/11/12 at 11:30 A.M.. The AM and SC both indicated the mentioned staff did not receive initial client specific training prior to working with clients #1, #2, #3 and #4. No documentation was submitted for review to indicate each staff received training on each clients training, behavioral and medical needs. 9-3-3(a)			

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W0268	483.450(a)(1)(i) CONDUCT TOWARD CLIENT These policies and procedures must promote the growth, development and independence of the client. Based on observation and interview, the facility failed for 1 of 4 clients residing at the group home (client #3), to promote her dignity by not ensuring she was groomed. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M.. During the entire observation client #3, a female client, was observed to have full facial hair. A facility day program observation was conducted on 5/10/12 from 2:00 P.M. until 3:20 P.M.. During the entire observation client #3 was observed to have full facial hair. A morning observation was conducted at the group home on 5/11/12 from 6:00 A.M. until 8:30 A.M.. During the entire observation client #3 was observed to have full facial hair. An interview with the Service Coordinator (SC) was conducted on	W0268	Service Coordinator will train DSPs on assisting client on #3 on shaving her facial hair. To ensure future compliance, Service Coordinator will monitor weekly for three months and bi-weekly thereafter.	06/10/2012

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	5/11/12 at 11:15 A.M.. The SC indicated the group home Direct Support Professional (DSP) staff are responsible for ensuring client #3 is prompted to shave. 9-3-5(a)			

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W0388	483.460(m)(1)(i) DRUG LABELING Labeling for drugs and biologicals must be based on currently accepted professional principles and practices. Based on observation, record review, and interview, the facility failed for 1 of 2 sampled clients (client #1), who received medication, to have the medication labeled from the pharmacy. Findings include: A morning observation was conducted at the group home on 5/11/12 from 6:00 A.M. until 8:30 A.M.. Client #1's medications were administered by Direct Support Professional (DSP) #1 at 7:15 A.M.. A bottle of Fluticasone Proprionate Nasal Spray (allergies) was taken from client #1's medication box. The bottle did not contain a pharmacy label and was not stored in a container with a label. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M.. Client #1's May 2012, Physicians Orders (PO) indicated: "Fluticasone Proprionate...give 2 sprays in each nostril daily." An interview with the Licensed Practical	W0388	Community Services Nurse will contact the Pharmacy to make sure that client #1 medicine is properly labeled. To ensure future compliance, Community Services will monitor monthly and thereafter.	06/10/2012

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	Nurse (LPN) was conducted on 5/11/12 at 11:50 P.M.. The LPN indicated all medications should have a pharmacy label on them. 9-3-6(a)			

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W0436	483.470(g)(2) SPACE AND EQUIPMENT The facility must furnish, maintain in good repair, and teach clients to use and to make informed choices about the use of dentures, eyeglasses, hearing and other communications aids, braces, and other devices identified by the interdisciplinary team as needed by the client. Based on observation, record review and interview, for 1 of 2 sampled clients who wore eyeglasses (client #1), the facility failed to encourage and teach client #1 to wear her eye glasses. Findings include: An evening observation was conducted at the group home on 5/9/12 from 5:20 P.M. until 7:45 P.M.. During the entire observation period client #1 did not wear her hearing aids. Client #2 was not prompted by staff to wear her hearing aids. A review of client #1's record was conducted on 5/11/12 at 10:00 A.M.. Review of client #1's most current hearing exam dated 12/8/11 indicated she wore hearing aids in both ears. Review of client #1's most current physical dated 7/15/11 indicated she wore hearing aids. Review of client #1's Individual Support Plan dated 8/15/11 indicated client #1 wore hearing aids.	W0436	Service Coordinator will train DSPs on prompting client #1 to wear her eye glasses and hearing aids, and client #2 to wear her hearing aid. To ensure future compliance, Service Coordinator will monitor weekly for three months and bi-weekly thereafter.	06/10/2012

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	An interview with the Service Coordinator (SC) was conducted at the facility's administrative office on 5/11/12 at 11:15 A.M.. The SC indicated client #1 wore hearing aids. When asked if staff should encourage and teach client #1 to wear her hearing aids, the SC stated "yes." 9-3-7(a)			

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ARC OF NORTHWEST INDIANA INC, THE	120 AVENUE C GRIFFITH, IN 46319

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
W0440	483.470(i)(1) EVACUATION DRILLS The facility must hold evacuation drills at least quarterly for each shift of personnel. Based on record review and interview, the facility failed to conduct evacuation drills during the evening shift (3:00 P.M. to 11:00 P.M.) during the second quarter (April 1st through June 30th) of 2011 which effected 4 of 4 clients living in the facility (clients #1, #2, #3 and #4.) Findings include: The facility's records were reviewed on 5/9/12 at 3:00 P.M.. The review failed to indicate the facility held an evacuation drill for clients #1, #2, #3 and #4 on the evening shift during the second quarter (April 1st through June 30th) of 2011. The Area Manager (AM) was interviewed on 5/11/12 at 11:30 A.M.. The AM indicated evacuation drills are to be run during each quarter for each shift. The AM further indicated there was no documentation available for review to indicate a drill was conducted for the mentioned shift/quarter. 9-3-7(a)	W0440	Area Manager will train staff on conducting evacuation drills at adequate times. To ensure future compliance, Area Manager will monitor monthly and thereafter.	06/10/2012